



Advising the Congress on Medicare issues

Alternative Payment Models (APMs) and the Merit-Based Incentive Payment System (MIPS)

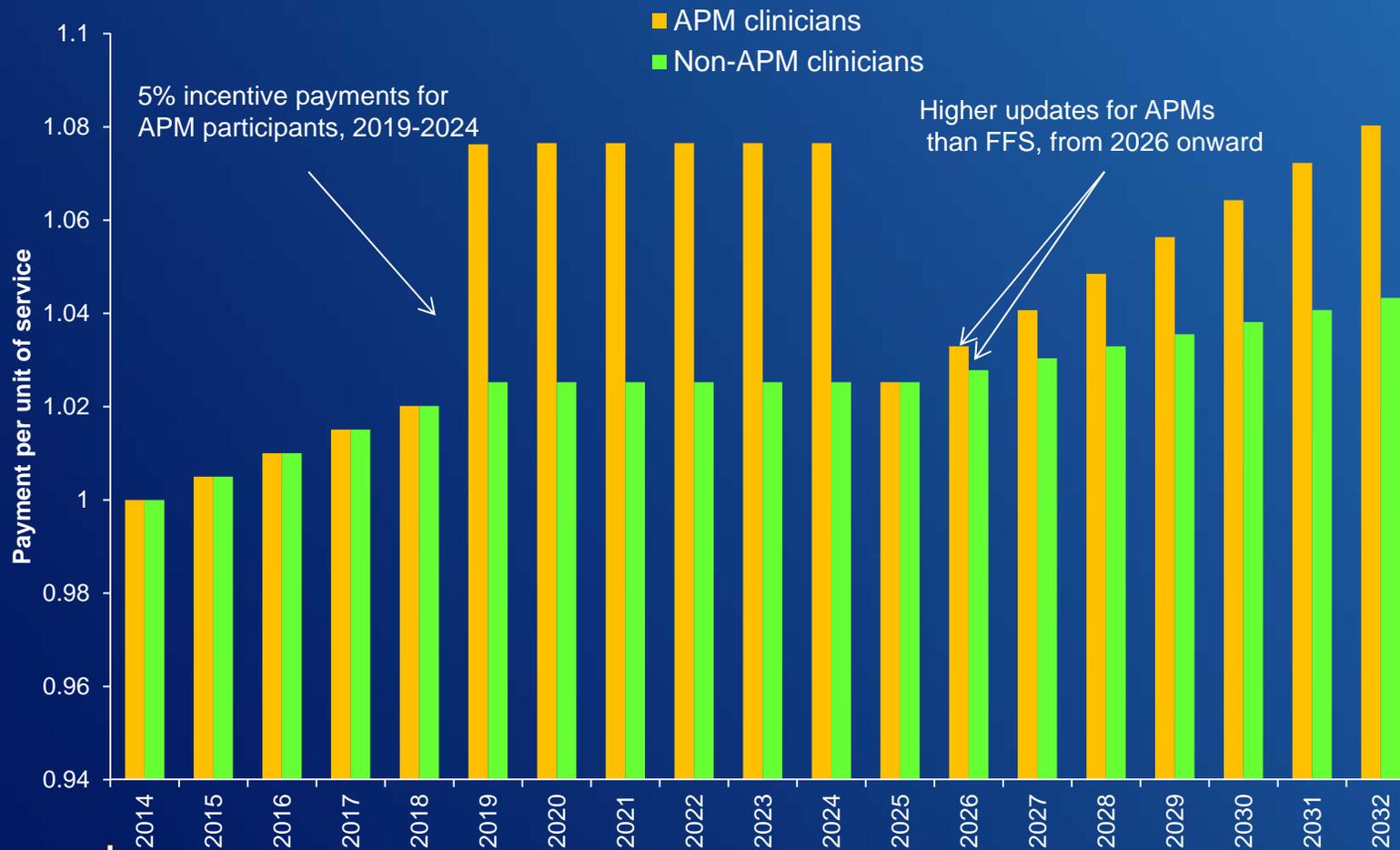
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Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Repeals SGR and establishes two paths of statutory payment updates for clinicians
- Incentive payments and higher updates for clinicians who participate in eligible Alternative Payment Models (APMs) than for others
- Merit-Based Incentive Payment System (MIPS) for clinicians not meeting APM criteria

Two payment update paths



Merit-Based Incentive Payment System (MIPS)

- Four components to MIPS
 - Quality
 - Resource use
 - Meaningful use of eHR
 - Clinical practice improvement activities
- Replaces three existing payment adjustments
- Starting in 2019 applies to clinicians who do not qualify as APM participants, maximum adjustment factor:
 - 4 percent in 2020
 - 7 percent 2021
 - 9 percent 2022 and after
- Eligible APMs must have comparable quality measures to MIPS

Difficult to measure individual clinician performance

- MIPS designed to assess clinician's performance at the individual level
- But many quality and resource use measures not reliable at the individual clinician level
- Most clinicians will look average
- May be able to identify persistent outliers only

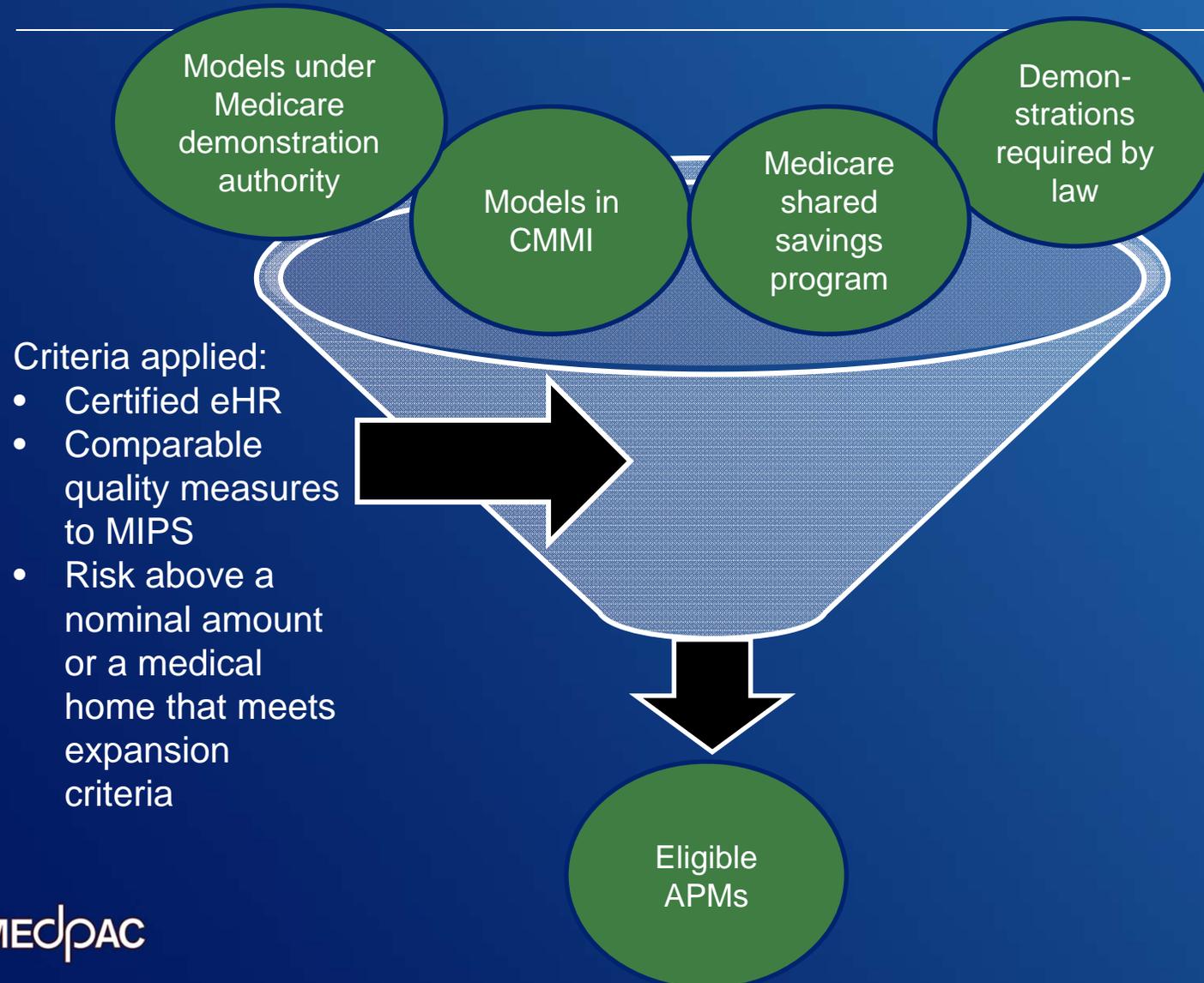
MIPS concerns

- MIPS will likely use some measures from Physician Quality Reporting System (PQRS) and eHR and add more factors
- PQRS weighted towards process measures
- Overbuilt system would add to burden on providers and CMS
- APMs have to use comparable quality measures to MIPS, could preclude use of more meaningful approach

Overview of Alternative Payment Model (APM) provisions

- Clinicians will receive additional payment if they participate in an eligible alternative payment model (APM)
 - Additional payments are 5% per year from 2019 to 2024
 - Higher update in 2026 and later
 - Excluded from MIPS
- Law establishes requirements for “eligible” APMs and the level of participation that allows clinicians to qualify for the incentive payment

Not all APMs will be “eligible” APMs



Clinician qualification for the APM incentive payment

- Clinician must have a specified share of FFS revenue (or beneficiaries) in an eligible APM to qualify for the incentive payment
 - 25% of spending in 2019 and 2020
 - 50% in 2021 and 2022
 - 75% in 2023 and later
- MA revenue not part of the calculation
- All-payer calculation option in 2021 and later

APM incentive payment: 5% each year from 2019 to 2024

- Delivered yearly in a lump sum based on prior year professional services revenue
- CMS shall establish processes for practitioners in APMs that do not use FFS payment
- 5% payment will not be included in shared savings calculations

Key implementation issues for CMS

- What spending is the APM responsible for ?
 - Only the services the APM's clinicians bill for
 - Spending in a bundle
 - Total Part A and Part B spending for a beneficiary
- How are clinicians and beneficiaries attributed to APMs?
- What is quality comparable to MIPS?
- What is risk above a nominal amount?

Option 1. APM responsible for *spending its clinicians bill for*

- Clinician likely to be in one APM
- Beneficiary could be in multiple APMs
- Unlikely to have sufficient 'n' to measure changes in spending or quality
- No incentive to coordinate care
- No incentive to control total spending
- No incentive to improve quality outcomes

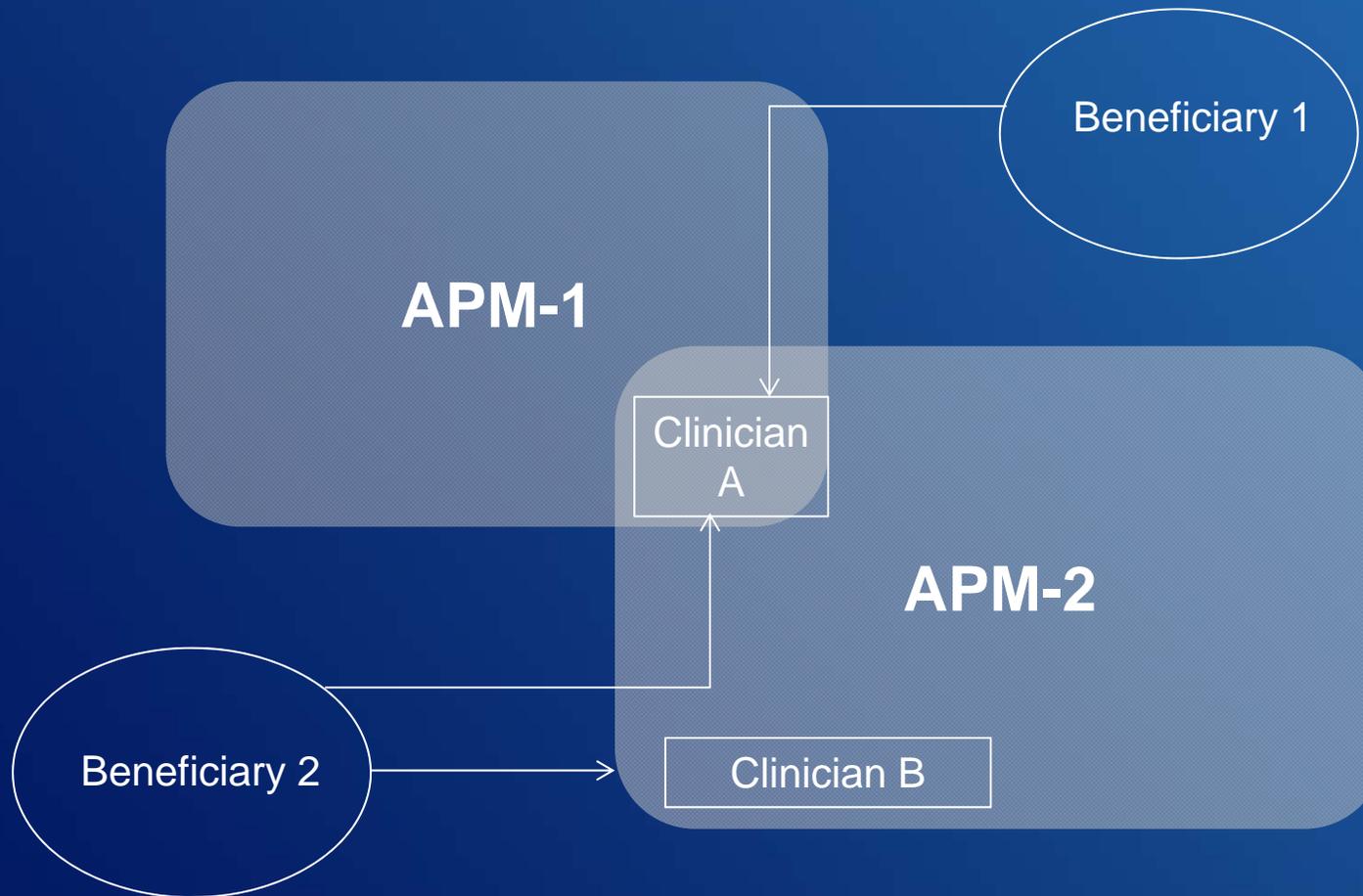
Option 2. APM responsible for *spending within a bundle*

- Clinician could be in multiple APMs
- Beneficiary could be in multiple APMs
- May have sufficient 'n' to measure changes in spending or quality
- Some incentive to coordinate care (within bundle)
- No incentive to control total spending
- Some incentive to improve quality outcomes

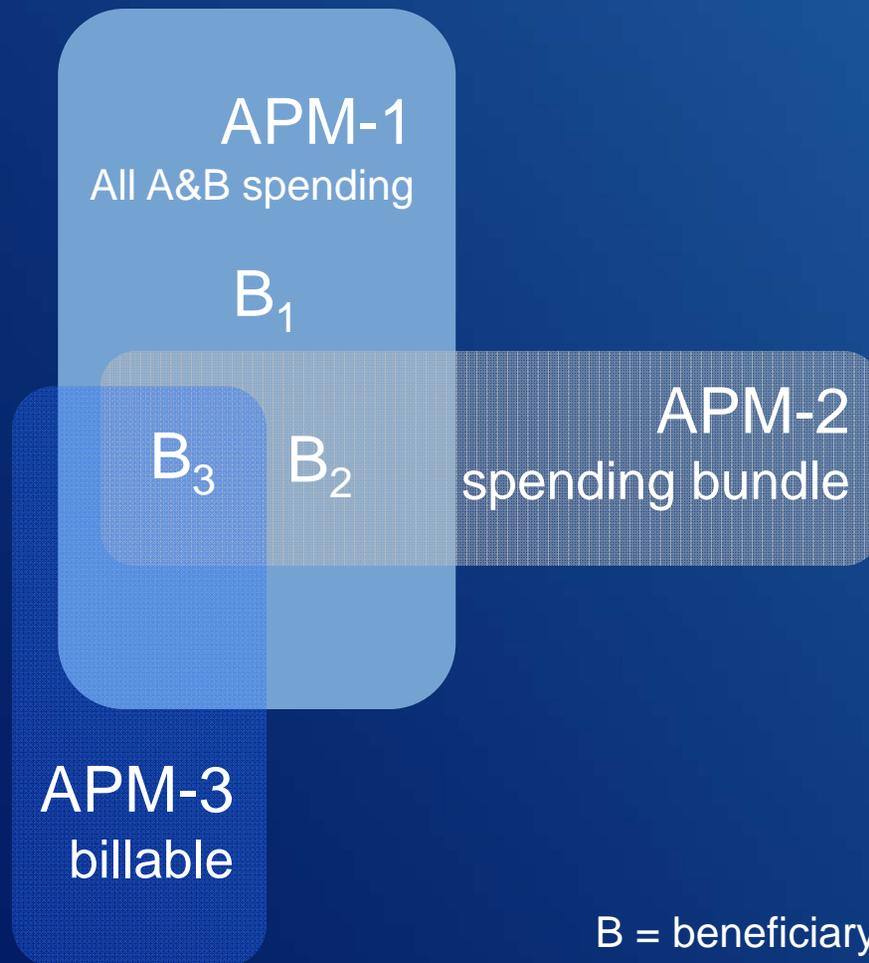
Option 3. APM responsible for *all of a beneficiary's A and B spending*

- Clinician would be in one APM (may differ by specialty)
- Beneficiary would be in one APM
- Likely to have sufficient 'n' to measure changes in spending or quality
- Strong incentive to coordinate care
- Strong incentive to control total spending
- Strong incentive to improve quality outcomes

Clinician/beneficiary/APM relationships could be complicated



APMs responsible for different spending will complicate program



If all three APMs have relationship to beneficiary:

- How is share of revenue counted?
- How are savings or losses shared?
- What if clinician is in multiple APMs?

B = beneficiary

Summary

- Two paths going forward
 - APMs
 - Other (FFS with MIPS)
- Strong interest in APMs
- But, if APMs not responsible for total spending
 - Incentives for care coordination diluted
 - Complexity could increase

Key questions

- How to define MIPS to minimize burden and emphasize outcomes?
- Should APMs be required to lower costs and increase quality?
 - Risk would have to be high enough
 - APMs would have to be large enough
- Balancing scope of spending and variety of APMs
- Should APMs have additional tools such as regulatory relief and sharing savings with beneficiaries?

Hypothetical APM model: based loosely on ACO

- APM would:
 - Be at risk for total spending (Part A and Part B)
 - Have sufficient numbers to detect changes in spending or quality
 - Have ability to share savings with beneficiaries
 - Be given regulatory relief
 - Have a single entity to assume risk
- Beneficiary in one APM per year
- Clinician in one APM per year (may differ by specialty)
- Not suggested definition, example to illustrate issues